DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

School Year 2011-2012 Student Enrollment Information

April 2011

1200 First Street, NE | Washington, DC 20002 | T 202.442.5885 | F 202.442.5026 | dcps.dc.gov

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

April 1, 2011

Dear DCPS Families,

Enclosed you will find the materials necessary to enroll your child in DCPS for the 2011-2012 school year. Please carefully review all the enclosed materials, and complete and return them – along with this checklist –to your child's school as soon as possible to secure your child's spot at his/her school. Our goal is to have all schools' enrollment completed by June 17, 2011.

The Student Enrollment Form has been printed to include your child's current enrollment information. If the information included has changed or is incorrect, please make changes directly on the form and review with your school's principal/registrar.

If you have any questions, please do not hesitate to contact your child's school directly or the DCPS Central Office at 202-442-5885.

NOTE: THE ANNUAL FARM (Free and Reduced Meals) FORM WILL NOT BE RELEASED UNTIL SUMMER 2011 AND IS NOT INCLUDED IN THIS PACKET

DCPS Enrollment Checklist	Parent/Guardian Initials	School Official Initials
Annual Student Enrollment Form	☐	☐
Home Language Survey	☐	☐
FERPA Notification	☐	☐
Release of Student Directory Information	☐	☐
Authorization for Release of Income Eligibility (providing information is optional)	☐	☐
Medicaid Consent Form	☐	☐
Student Health Packet	☐	☐

_____

Parent/Guardian Signature ***Date***

_____

School Official Signature ***Date***

****** This checklist should be retained at the local school. ******

DISTRICT OF COLUMBIA PUBLIC SCHOOLS

ANNUAL STUDENT ENROLLMENT PROFILE
School Year 2011 - 2012

Grade in School Year 2011 - 2012: ☐ **School in SY 2011 - 2012:** _____

Student ID #: _____ **(Print all information)**

STUDENT INFORMATION

1. Last Name	2. First Name	3. Middle Name	4. Country of Birth	5. Date of Birth

6. Address	7. Apt No.	8. Home Telephone Number ( )

9. City	10. State	11. ZIP Code

12. Student's Gender ☐ Male ☐ Female ☐ Decline to Respond	13. Student's Home Language(s)

14. School Last Attended/Address (if DCPS, name of school only): ☐ Private ☐ Public ☐ Charter ☐ Other	Address		
	City	State	Zip Code

15. Health Insurance or Medicaid Information Provider: _____ Policy Number: _____ List any medical conditions of which the school should be aware _____	For students new to DCPS, please indicate whether or not your child has a(n): IEP (Individualized Education Program) **Y☐ or N ☐** If yes, IEP Review Date: _____ Section 504 Accommodation Plan **Y☐ or N ☐**

16. Student's Siblings	A.	B.	C.
Student's Siblings' Schools			

17. Ethnic Designation ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino	17b. Race - choose one or more ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaska Native ☐ Asian ☐ White

PARENT/GUARDIAN INFORMATION AND OTHER PRIMARY CAREGIVER INFORMATION

18. Parent or Guardian	Relationship	☐ Active Military ☐ Reserve Military

Address	Apt. No.

City	State	ZIP Code

Email Address	Preferred Language of Communication

Cell Number ( )	Work Number ( )

Employer's Name/Address		
City	State	ZIP Code

19. Parent or Guardian	Relationship	☐ Active Military ☐ Reserve Military

Address	Apt. No.

City	State	ZIP Code

Email Address	Preferred Language of Communication

Cell Number ( )	Work Number ( )

Employer's Name/Address		
City	State	ZIP Code

IN CASE OF EMERGENCY

20. Emergency Contact Person (other than parent/guardian)	Relationship	Home Number ( )	Work Number ( )

Address	City	State	Zip Code	Cell Number ( )

RESIDENCY STATUS (Check One ☑)

21. ☐ D.C. Resident (Student and parent or guardian live in D.C.)
☐ Nonresident + Receipt of payment for nonresident tuition attached

HOUSING STATUS (Check One ☑)

22. ☐ Permanent	☐	Unaccompanied Youth	☐	Other Temporary Housing
☐ Shelter	☐	Shared Housing	☐	Foster Care
☐ Hotel/Motel	☐	Awaiting Foster Care		

I completed this form and I certify that the information above is accurate. I understand that providing false information for purposes of defrauding the government is punishable by law.

_____ _____

***Signature of Parent/ Guardian with Whom Student Lives or Student who is 18 or older** **Date**

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

HOME LANGUAGE SURVEY	DCPS ID NUMBER:
SCHOOL NAME:	STUDENT NAME:

Parent Name:_____ Parent's Signature:_____ Date:_____

This document MUST be signed and dated by the parent or guardian.

ENGLISH (Please answer ALL five questions.)

Please make sure to provide your name and signature in the space provided above

		Yes	No
1)	Is a language OTHER THAN English used at home?	☐	☐
2)	What language did your child first speak?		
	○ English ○ Spanish ○ Amharic ○ French		
	○ Chinese ○ Vietnamese ○ Other (specify): _____		
3)	Does your child frequently speak a language other than English for communication at home?	☐	☐
4)	Was your child born in a country OUTSIDE OF THE USA?	☐	☐
5)	What is your relationship to the child?		
	○ Mother ○ Father ○ Guardian ○ Other (specify): _____		

AMHARIC (እባክዎን አምስቱንም ጥያቄዎች በሙሉ ይመልሱ)

ከላይ በተጠቀሰው ባዶ ቦታ ላይ እባክዎን ስምዎንና ፊርማዎን ማስፈርዎን ያረጋግጡ

		አዎ	የለም
1)	በቤትዎ ውስጥ ከእንግሊዘኛ ሌላ የምትጠቀሙበት ቋንቋ አለ ወይ?	☐	☐
2)	በመጀመሪያ ልጅዎ አፉን የፈታው በምን ቋንቋ ነው?		
	○ እንግሊዘኛ ○ ስፓኒሽ ○ አማርኛ ○ ፈረንሳይኛ		
	○ ቻይንኛ ○ ቪየትናምኛ ○ ሌላ (ይጠቀስ) _____		
3)	አብዛኛውን ጊዜ ልጅዎ በቤት ውስጥ ለመግባቢያ ከእንግሊዘኛ ሌላ በሌላ ቋንቋ ይጠቀማል ወይ?	☐	☐
4)	ልጅዎ ከአሜሪካ ግዛት ከዕል ውጪ ነው ወይ የተወለደው?	☐	☐
5)	ከከልጁ ጋር ያለዎት ዝምድና ምንድን ነው?		
	○ እናት ○ አባት ○ አሳዳጊ ○ ሌላ (ይጠቀስ) _____		

SPANISH (Por favor responda a TODAS las cinco preguntas.)

Por favor asegurese de escribir y firmar su nombre en el espacio disponible arriba

		Sí	No
1)	¿Se habla otro idioma ADEMÁS DE INGLÉS en la casa?	☐	☐
2)	¿En qué idioma comenzó a hablar su hijo/a?		
	○ Inglés ○ Español ○ Amárico ○ Francés		
	○ Chino ○ Vietnamés ○ Otro (especifique): _____		
3)	¿Habla frecuentemente su niño/a otro idioma ADEMÁS DE INGLÉS para comunicarse en la casa?	☐	☐
4)	¿Nació su hijo/a en otro país que NO sea EE.UU. (USA)?	☐	☐
5)	¿Cuál es su relación al niño/a?		
	○ Madre ○ Padre ○ Tutor ○ Otro (especifique): _____		

FRENCH (S'il vous plaît respondez à TOUTES les cinq questions.)

Veuillez vous assurer de donner votre nom et signature dans l'espace ci-dessus indiqué

		Oui	Non
1)	Est-ce-que vous parlez une langue AUTRE QUE L'ANGLAIS chez vous?	☐	☐
2)	Quelle langue votre enfant utilise lorsqu'il commence à parler?		
	○ Anglais ○ Espagnol ○ Amharic ○ Français		
	○ Chinois ○ Vietnamien ○ Autre: _____		
3)	Chez vous, pour communiquer, votre enfant emploie-t-il fréquemment une langue AUTRE QUE L'ANGLAIS?	☐	☐
4)	Votre enfant était-il né HORS DES ÉTATS-UNIS?	☐	☐
5)	Quel est votre lien de parenté avec l'enfant?		
	○ Mère ○ Père ○ Tuteur ○ Autre: _____		

CHINESE (请回答以下所有五个问题)

请在以上家长姓名处写上您的姓名和在家长签名处签上您的名字

		是	否
1)	您家庭中是否使用不是英语的另一种语言?	☐	☐
2)	您孩子最初学说话时说以下哪种语言?		
	○ 英语 ○ 西班牙语 ○ 阿姆哈拉语 ○ 法语		
	○ 汉语 ○ 越南语 ○ 其他语言 (说明): _____		
3)	您孩子在家是否经常使用不是英语的另一语言与家人沟通?	☐	☐
4)	您孩子是否在美国以外的国家出生?	☐	☐
5)	您与孩子的关系是:		

VIETNAMESE (Xin vui lòng trả lời TẤT CẢ năm câu hỏi.)

Xin quý vị chắc chắn là đã viết tên và ký tên của quý vị vào khoảng trống phía tên

		Có	Không
1)	Ở nhà có thường sử dụng thứ tiếng nào KHÁC HƠN Anh Ngữ không?	☐	☐
2)	Con quý vị đã nói thứ tiếng nào trước nhất?		
	○ Anh Ngữ ○ Tây Ban Ngữ ○ Am-ha-ric ○ Pháp Ngữ		
	○ Hoa Ngữ ○ Việt Ngữ ○ Ngôn ngữ khác: _____		
3)	Ở nhà con em có thường sử dụng một thứ tiếng nào khác hơn Anh Ngữ khi nói chuyện hay không?	☐	☐
4)	Con quý vị đã sinh ra ở một NƯỚC NÀO KHÁC HOA KỲ không?	☐	☐
5)	Liên hệ của quý vị với đứa trẻ?		

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

Notification of Rights under FERPA

The Family Educational Rights and Privacy Act (FERPA) affords parents and students age 18 or older ("eligible students") certain rights with respect to the student's education records. These rights are:

(1) The right to inspect and review the student's education records within 45 days of the day the District of Columbia Public Schools (DCPS) receives a request for access. Parents or eligible students should submit to the school principal a written request that identifies the record(s) they wish to inspect. The school principal or other appropriate school official will make arrangements for access and notify the parent or eligible student of the time and place where the records may be inspected.

(2) The right to request the amendment of the student's education records that the parent or eligible student believes are inaccurate, misleading or otherwise in violation of the student's privacy rights under FERPA. Parents or eligible students may write the school principal, clearly identify the part of the record they want changed, and specify why it should be changed. If DCPS decides not to amend the record as requested by the parent or eligible student, the school will notify the parent or eligible student of the decision and advise them of their right to a hearing regarding the request for amendment. Additional information regarding the hearing procedures will be provided to the parent or eligible student when notified of the right to a hearing.

(3) The right to consent to disclosures of personally identifiable information contained in the student's education records, except to the extent that FERPA authorizes disclosure without consent. FERPA authorizes disclosure without consent to school officials whom DCPS has determined to have legitimate educational interests. A school official is a person employed by DCPS as an administrator, supervisor, instructor, or support staff member (including health or medical staff and law enforcement unit personnel); a person or company with whom DCPS has contracted to perform a special task (such as an attorney, auditor, medical consultant, or therapist); or a parent or student serving on an official committee, such as a disciplinary or grievance committee, or assisting another school official in performing his or her tasks. A school official has a legitimate educational interest if the official needs to review an education record in order to fulfill his or her professional responsibility.

(4) The right to withhold directory information. At its discretion, DCPS may disclose basic "directory information" that is generally not considered harmful or an invasion of privacy without the consent of parents or eligible students in accordance with the provisions of District law and FERPA. Directory information includes:

A. Student Name
B. Student Address
C. Student Telephone Listing
D. Name of School Attending
E. Participation in Officially Recognized Activities and Sports
F. Weight and Height of Members of Athletic Teams
G. Diplomas and Awards Received
H. Student's Date and Place of Birth
I. Names of Schools Previously Attended
J. Dates of Attendance

Parents or eligible students may instruct DCPS to withhold any or all of the information identified above, by completing the "Release of Student Directory Information" Form, available at the time of registration, or by notifying the Office of Data and Accountability at 1200 First St. NE, 12th Floor, Washington, DC 20002, in writing within two weeks after the first day of the school year. **Please note that you should only fill out this form if you want DCPS to obtain your prior written consent before disclosing directory information.**

(5) The right to file a complaint with the U.S. Department of Education concerning alleged failures by DCPS to comply with the requirements of FERPA. The name and address of the office that administers FERPA are:

Family Policy Compliance Office
U.S. Department of Education
400 Maryland Avenue, SW
Washington, DC 20202-5901

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

Release of Student Directory Information

School Year _____

To: All Parents and Adult Students (18 years of age and older)

The Family Educational Rights and Privacy Act (FERPA) is a federal law that requires DCPS, with certain exceptions, to get your permission before disclosing personally identifiable information from education records. However, DCPS may disclose basic "directory information" that is generally not considered harmful or an invasion of privacy without your consent. The primary purpose of directory information disclosure is to allow DCPS to include this type of information in certain school publications such as pamphlets for drama productions, graduation programs, honor rolls or sports team activity sheets for football, basketball, etc. Directory information can also be disclosed to outside organizations such as federal and state agencies offering jobs and educational benefits, media sources, and companies that make class rings and publish yearbooks.

The information listed below has been designated as directory information under District of Columbia law and FERPA, and may therefore be released at the discretion of DCPS. You have the right to instruct DCPS that it may not release any or all of this information without obtaining your prior written consent by completing this form. Your decision on this form will be valid for the remainder of the current school year. **A new Release of Student Directory Information form must be completed each school year.**

Please place a check mark on the line beside any directory information items listed below that you do not want DCPS to disclose without your consent, if any.

____	Student Name	____	Weight and Height of Members of Athletic Teams
____	Student Address	____	Diplomas and Awards Received
____	Student Telephone Listing	____	Student's Date and Place of Birth
____	Name of School Attending	____	Names of Schools Previously Attended
____	Participation in Officially Recognized Activities and Sports	____	Dates of Attendance

By signing below I am giving written notification to DCPS that it may not disclose the directory information items I have placed a check mark beside above unless I give prior written consent. I understand that such information may still be disclosed by DCPS if disclosure is otherwise permissible under FERPA.

_____

Student Name (please print)

_____

Parent/Guardian Name (please print) Parent/Guardian Signature Date

_____

If at least 18 years old, Student Signature Date

******If this form is not returned by September 15, it will be assumed that the above information may be designated as directory information for the remainder of the school year.******

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

Right to Opt Out of Release of Information to Military Recruiters (Students in Grades 7–12 & Ungraded Students Only)

Federal laws require that local education agencies (LEAs) such as DCPS provide military recruiters, upon request, with the name, address, and telephone number of secondary students unless the student or parent/legal guardian has advised the LEA in writing that he/she does not want the student's information disclosed without prior written consent. Such advisement must take place within 30 days of the notification of these rights by the school, and may be done by completing the form below:

_____ As a student who has reached the age of 18, I request that DCPS not release my directory information to the Armed Services, military recruiters, service academies or military schools.

_____ As a parent/legal guardian, I request that DCPS not release the directory information for the student indicated above to the Armed Services, military recruiters, service academies or military schools.

Student's Signature Date

Parent/Legal Guardian's Signature Date

Authorization for Release of Income Eligibility Information NOTE: PROVIDING THIS INFORMATION IS OPTIONAL

The District of Columbia Public Schools (DCPS) is working in collaboration with the District of Columbia Office of Tax and Revenue (OTR) to verify household income for the purpose of determining eligibility for federally funded educational activities and services. The exchange of information between OTR and DCPS will benefit families by eliminating the paperwork burden for families who would otherwise be required to provide proof of income (W2, pay check stubs) for federally funded activities. This information has no bearing on your child's eligibility to enroll at a DCPS school. If you do not have a social security number or tax identification number, you do not need to sign this form.

By signing below, you authorize OTR to determine if your household income level meets income eligibility guidelines for federally funded activities and services during the 2011-2012 school year. You also authorize OTR to consult any tax information you have provided to OTR in order to perform this evaluation. OTR will not share your exact household income with DCPS. The information released by the OTR to DCPS will be kept confidential and is for this stated use only.

SIGNATURE OF TAXPAYER
(PARENT/HEAD OF HOUSEHOLD/GUARDIAN)

DATE

PRINTED NAME OF TAXPAYER

SOCIAL SECURITY NUMBER OR TAX IDENTIFICATION NUMBER

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

DCPS Media Release Form

I, _____, (Parent/Guardian's Name)hereby irrevocably grant to District of Columbia Public Schools (DCPS) and the District of Columbia, their successors, and their assignees the right to record the image and/or voice and use the artwork and /or written work of my child, _____, (Child's Name) on videotape, on film, in photographs, in digital media and in any other form of electronic or print medium and to edit such recording at their discretion.

I understand that my child's full name, address and biographical information will not be made public. I further grant District of Columbia Public Schools (DCPS) and the District of Columbia , their successors, and their assignees the right to use, and to allow others to use, my child's image and/or voice on the internet, in brochures, and in any other medium and hereby consent to such use.

I hereby release District of Columbia Public Schools (DCPS) and the District of Columbia , their successors, and their assignees and anyone using my child's image and/or voice, artwork and/or written work pursuant to this release from any and all claims, damages, liabilities, costs and expenses which I or my child now have or may hereafter have by reason of any use thereof.

I understand that the provisions of this release are legally binding.

_____

Parent/Guardian (if student is under 18) [Print Name]

_____

Signature Date

Student's School: _____ Student's Grade:_____

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

DCPS Residency Verification Guidelines

Every school year, DCPS is required to verify residency for each student. The following guidelines provide a comprehensive view of the required documentation for proving residency for the 2011 – 2012 School year.

Residency Key Facts:

- Only residents of the District of Columbia are eligible to receive a free public education in the District.
- The current Residency Verification Rules are designed to ensure that only those students who are District residents attend public schools in the District without paying tuition.

Procedures:

- Schools *are not* required to photocopy residency proofs; however, if the Residency Form is called into question during the audit of the student enrollment count, schools may be required to obtain and provide photocopies.
- Persons enrolling a student must show *original documents* as proof of residency.
- Residency must be established by October 5, 2011, or within 10 days of the time of initial enrollment.
- The annual verification shall take place no sooner than April 1 of the current school year (ends Oct. 5, 2011).
- Residency status shall be established through the use of satisfactory documentation as provided in requirement (1) or (2) below:

Requirements for Providing One (1) Residency Document

One of the following items will suffice to establish District of Columbia residency:	
Item Accepted for Verification of DC Residency:	**Item Must Show:**
1. A **pay stub**	a. Issue date within the past 45 days; b. Name of person enrolling the student; c. Current DC home address; and d. Withholding of DC taxes for the current tax year.
2. Proof of **financial assistance from the DC Government**, in the form of either a: a. Temporary Assistance for Needy Families (TANF) verification of income notice or recertification approval letter; b. Medicaid approval letter or recertification letter; c. Housing assistance letter from a housing shelter, including contact name and phone number or a letter from the Housing Authority; or d. Proof of receipt of financial assistance from another DC Government program.	a. Issue date within the past 12 months; b. Name of person enrolling the student; and c. Current DC home address.
3. **Supplemental Security Income annual benefits notification**	a. Issue date within the past 12 months; b. Name of person enrolling the student; and c. Current DC home address.
4. A **tax information authorization waiver form** certified by the DC Office of Tax and Revenue	a. Name of person enrolling the student; b. Evidence of payment of DC taxes for the previous tax year; and c. Current DC home address.
5. **Verification Letter** and **Military Housing Orders;** or **DEERS Statement***	a. Name of student and person enrolling the student; and b. Current DC home address.

6. Proof that a child is a **ward of the District of Columbia**, in the form of a **Court Order**.	a. Name of student.
7. An **embassy letter**	a. Issue date after April 1 of the current school year; b. Name of person enrolling the student; c. Official seal; and d. Statement indicating that the person enrolling the student, and the student currently live on embassy property in DC, with the DC address.
8.	a.

For the purpose of verifying DC residency, the following items ***cannot*** be submitted as proof of payment for District of Columbia personal income tax: (1) a W-2 form, (2) a federal income tax return, or (3) a District income tax return (unless certified by the DC Office of Tax and Revenue).

For the purpose of verifying DC residency, the following items ***cannot*** be submitted as proof of financial assistance from the DC Government: (1) a TANF identification card, (2) a Medicaid identification card, (3) an identification card from a District employer (including DC Government), or (4) a letter from a District resident.

*DEERS Statements are obtained at the base MPF administrative office. If the DEERS statement shows the dependents but does not show the current address, it can be combined with a residency verification letter from the Housing Management Branch.

Requirements for Providing Two (2) Residency Documents

In the absence of items listed on the other side of the page, two (2) of the items listed below will suffice as proof of residency in the District of Columbia. The address and name on each submitted item must be the same.	
Item Accepted for Verification of DC Residency:	**Item Must Show:**
1. Unexpired **DC motor vehicle registration**	a. Name of person enrolling the student; and b. Current DC home address.
2. Unexpired **lease or rental agreement**	a. Name of the person enrolling the student; b. Current DC home address; and c. Receipt of a payment or canceled check indicating payment of rent within the past two (2) months.
3. Unexpired **DC motor vehicle operator's permit** or other official non-driver identification	a. Name of person enrolling the student; and b. Current DC home address.
4. **One utility bill** (only gas, electric and water bills are acceptable)	a. Name of person enrolling the student; b. Current DC home address; and c. A separate receipt of payment or cancelled checks indicating payment for the utility bill within the past two (2) months.

For the purpose of verifying DC residency, the following items ***cannot*** be submitted in place of a DC motor vehicle registration or operator's permit: (1) a title to a vehicle, or (2) vehicle insurance.

For the purpose of verifying DC residency, the following items ***cannot*** be submitted in place of a utility bill: (1) a telephone bill, or (2) a cable bill.

Only the documents shown on the Residency Verification Form and in these guidelines are acceptable for proving District residency. While a parent or caregiver may provide other types of documents, they should not be accepted.

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS
Office of Special Education

CONSENT FOR MEDICAID REIMBURSEMENT

- ☐ I am providing consent as indicated by my signature below
- ☐ I am providing consent if my child becomes Medicaid eligible in the future as indicated by my signature below
- ☐ I decline to provide consent to bill for Medicaid reimbursable services

Dear Parent or Guardian:

The District of Columbia Public Schools (DCPS) and the Office of the State Superintendent for Education (OSSE) are eligible to receive federal Medicaid reimbursement for certain health related services provided to your child when the services meet state Medicaid requirements and are provided in accordance with your child's Individualized Education Plan (IEP). These services may include any of the following:

- Skilled Nursing Services
- Psychological Evaluation
- Behavioral Support Services
- Orientation and Mobility Services and Assessments
- Speech-Language Pathology Services and Assessments
- Occupational Therapy Services and Assessments
- Physical Therapy Services and Assessments
- Personal Care
- Nutrition
- Specialized Transportation

In order for DCPS and OSSE to receive Medicaid reimbursement for health related services provided to your child, each agency must submit a claim for reimbursement containing personal information about your child to the Department of Health Care Finance (DHCF). DHCF will not be allowed to use this information for any other purpose and will be required to keep this information confidential. The Family Educational Rights and Privacy Act (FERPA) require that DCPS and OSSE obtain your written consent to share or disclose personally identifiable information from your child's educational records. In addition, the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) requires that DCPS and OSSE obtain your written consent to bill for Medicaid-eligible health related services provided to your child. By completing and signing this form, you will help DCPS and OSSE meet these consent requirements.

Upon written request, you or your child may receive a copy of the information shared with DHCF. Your consent is voluntary and may be revoked at any time. If you do revoke consent, the revocation is not retroactive, meaning that your previous consent is still valid regarding all information shared prior to you revoking consent. By giving consent to bill Medicaid insurance for health related services provided to your child, you will not incur an out-of-pocket expense such as payment of a deductible or co-pay amount and you will not decrease your available lifetime insurance coverage, increase premiums or be subject to the discontinuation of benefits. In addition, if you refuse to provide this consent, DCPS and OSSE will still ensure that all required special education and health related services are provided to your child at no cost to you.

Parental Consent

By signing below, I voluntarily give my consent to DCPS and OSSE to share with DHCF my child's name, primary address, date of birth, social security number, Medicaid number, IEP, and all information about health related services provided to my child, the dates and frequency of the services provided, and special education assessments and evaluations related to my child. In addition, I voluntarily give my consent to DCPS to submit reimbursement claims to DHCF for Medicaid billable health related services provided to my child, as indicated in my child's IEP, and I voluntarily give my consent to OSSE to submit reimbursement claims to DHCF for Medicaid billable specialized transportation services provided to my child, as indicated in my child's IEP. I also authorize DCPS and OSSE to release the information described above to state and/or federal Medicaid representatives for the purpose(s) of determining eligibility and/or completing audit/review requests. I understand that, unless I revoke my consent in writing, this consent will remain in effect for 365 days from the date of my signature.

PARENT OR GUARDIAN SIGNATURE _____ DATE _____

STUDENT'S NAME _____ STUDENT ID _____

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

School Health Checklist:

Please turn in the following forms to your child's school when you enroll your child. Please know that DC law requires that all students be current on immunizations to attend school.

- **Universal Health Certificate – NEW THIS YEAR: DC law now requires Universal Health Certificates for children entering all grades. Each student must submit a Universal Health Certificate that documents a physical completed within the past 365 days.** Have your child's physician or nurse practitioner complete the Universal Health Certificate Form. The form collects required information on your child's health. Your child must have required immunizations, as well as have a physical exam and tuberculosis screening. Children in Headstart, Early Childhood Programs, and older than 26 months up to 6 years old who have not yet been tested for lead exposure also need lead screening.
    - If your child participates in athletics, the Universal Health Certificate will expire 365 days from the date of the exam listed on the form. To remain eligible for athletics, an updated Universal Health Certificate must be submitted to the school when a new physical occurs.
- **Immunization Documentation** – Age-appropriate immunizations should be documented on the Universal Health Certificate.
- **Oral Health Assessment Form** – Have your child's dentist complete this form if your child is entering grades Pre-School, Pre-K, K, 1, 3, 5, 7, 9 and 11.
- **Medication Orders** – If your child needs medication or medical intervention during the school day, please speak with the principal and nurse about your child's physical health or behavioral health condition and intervention requirements. **See Below.**
- **HPV Vaccine Refusal Form** – If you decide your 6th, 7th or 8th grade female child will not get the HPV vaccine, please turn in this form. Please note: If you need to file an exemption for other vaccines, please contact your child's school nurse.

Tell me more about Immunizations...

- All students must have their age-appropriate immunizations. See flyer in packet about all required immunizations.
- Please schedule a visit with your child's physician soon if your child's immunizations are not up to date. Some immunizations require more than one dose with return visits.
- If you have questions about DC's immunization requirements, please discuss them with your child's physician. **You can also contact the DC Department of Health Immunization Division at (202) 576-7130.**

Tell me more about medication orders ...

- Forms are available with your school nurse for the required parent/guardian administration of medication permission and the physician medication order. They can also be found online at: www.dcps.dc.gov.
- Students who are allowed to self-administer asthma or anaphylaxis while at school must have a valid medication action plan signed by the student's parent or guardian, and physician. You can get these forms from your school nurse or online at the above webpage.

Contact your child's health providers to complete these forms.

If you have any questions about the Student Health Packet, please feel free to contact Andrea Shore, Health Services Manager, at DCPS: 202-719-6555 or Andrea.Shore@dc.gov.
You can find copies of these forms on the DCPS website: www.dcps.dc.gov.

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Part 1: Child's Personal Information **Parent/Guardian: *Please complete Part 1 clearly and completely & sign Part 5 below.***

Child's Last Name:	*Child's First & Middle Name:*	*Date of Birth:*	*Gender:* ☐M ☐F	*Race/Ethnicity:* ☐White Non Hispanic ☐Black Non Hispanic ☐Hispanic ☐Asian or Pacific Islander ☐Other_____
Parent or Guardian Name:	*Telephone:* ☐Home ☐Cell ☐Work	*Home Address:*		*Ward:*
Emergency Contact Person:	*Emergency Number:* ☐Home ☐Cell ☐Work	*City/State (if other than D.C.)*		*Zip code:*
School or Child Care Facility:	☐Medicaid ☐Private Insurance ☐None ☐Other_____	*Primary Care Provider (PCP):*		

Part 2: Child's Health History, Examination & Recommendations **Health Provider: Form must be fully completed.**

DATE OF HEALTH EXAM:	WT ☐ LBS ☐ KG	HT ☐ IN ☐ CM	BP: (>3 yrs) ☐ NML ☐ABNL	Body Mass Index (>2 yrs) (BMI)_____ %_____
HGB / HCT *(Required for Head Start)*	Vision Screening ☐ Glasses ☐ Referred Right 20/____ Left 20/____		Hearing Screening Pass_____ Fail_____ ☐ Referred	

HEALTH CONCERNS:			REFERRED or TREATED	HEALTH CONCERNS:			REFERRED or TREATED
Asthma	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Language/Speech	☐ NONE	☐ YES	☐ Referred ☐ Under Rx
Seizure	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Development/ Behavioral	☐ NONE	☐ YES	☐ Referred ☐ Under Rx
Diabetes	☐ NO	☐ YES	☐ Referred ☐ Under Rx	Other_____	☐ NONE	☐ YES	☐ Referred ☐ Under Rx

ANNUAL DENTIST VISIT: (Age 3 and older): Has the child seen a Dentist/Dental Provider within the last year? ☐ YES ☐ NO ☐ Referred

A. Significant health history, conditions, communicable illness, or restrictions that may affect school, child care, sports, or camp.
☐ NONE ☐ YES, please detail:

_____

_____

B. Significant food/medication/environmental allergies that may require *emergency medical care* at school, child care, camp, or sports activity.
☐ NONE ☐ YES, please detail: _____

_____

C. Long-term medications, over-the-counter-drugs (OTC) or special care requirements.
☐ NONE ☐ YES, please detail (For any medications or treatment required during school hours, a Physician's Medication Authorization Order should be submitted with this form)

_____

_____

_____

Part 3: Tuberculosis & Lead Exposure Risk Assessment & Testing:

TB RISK ASSESSMENTS	☐ HIGH→ ☐ LOW	Tuberculin Skin Test (TST) DATE:	☐ NEGATIVE ☐ POSITIVE	If **TST** Positive ☐ CXR NEGATIVE ☐ CXR POSITIVE ☐ TREATED	**Health Provider:** POSITIVE TST should be referred to PCP for evaluation. For questions, call T.B. Control: 202-698-4040
LEAD EXPOSURE RISKS	☐ YES→ ☐ NO	LEAD TEST DATE:	RESULT:	**Health Provider:** *ALL* lead levels must be reported to DC Childhood Lead Poisoning Prevention Program: Fax: 202-481-3770	

Part 4: Required Provider Certification and Signature

☐ YES ☐ NO This child has been appropriately examined & health history reviewed. At time of exam, this child is in satisfactory health to participate in all school, camp or child care activities except as noted above.

☐ YES ☐ NO This athlete is cleared for competitive sports.

☐ YES ☐ NO Age-appropriate health screening requirements performed within current year. If no, please explain:

_____

_____

Print Name	MD/NP Signature		Date
Address		Phone	Fax

Part 5: Required Parental/Guardian Signatures. (Release of Health Information)

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, child care, camp, or appropriate DC Government Agency.

Print Name **Signature** **Date**

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Student's Name: _____/_____/_____ Date of Birth:_____/_____/_____
Last First Middle Mo. /Day/ Yr.

Sex: ☐ Male ☐ Female School or Child Care Facility:_____

Section 1: Immunization: Please fill in or attach equivalent copy with provider signature and date.

IMMUNIZATIONS	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN						
Diphtheria,Tetanus, Pertussis (DTP,DTaP)	1	2	3	4	5		
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4	5		
Tdap Booster	1						
Haemophilus influenza Type b (Hib)	1	2	3	4			
Hepatitis B (HepB)	1	2	3	4			
Polio (IPV, OPV)	1	2	3	4			
Measles, Mumps, Rubella (MMR)	1	2					
Measles	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Chicken Pox Disease History: Yes ☐ When: Month_____ Year_____ Verified by:_____ (Health Care Provider) Name & Title				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2					
Meningococcal Vaccine	1						
Human Papillomavirus (HPV)	1	2	3				
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				
Other							

_____ _____ _____
Signature of Medical Provider Print Name or Stamp Date

Section 2: MEDICAL EXEMPTION. For Health Care Provider Use Only.

I certify that the above student has a valid medical contraindication to being immunized at the time against: (check all that apply)

Diphtheria: (__) Tetanus: (__) Pertussis: (__) Hib: (__) HepB: (__) Polio: (__) Measles: (__) Mumps: (__) Rubella: (__) Varicella: (__) Pneumococcal: (__)

HepA: (__) Meningococcal: (__) HPV: (__)

Reason:_____

This is a permanent condition (___) or temporary condition (___) until ____/____/____.

_____ _____ _____
Signature of Medical Provider Print Name or Stamp Date

Section 3: Alternative Proof of Immunity. To be completed by Health Care Provider or Health Official.

I certify that the student named above has laboratory evidence of immunity: (Check all that apply & attach a copy of titer results)

Diphtheria: (__) Tetanus: (__) Pertussis: (__) Hib: (__) HepB: (__) Polio: (__) Measles: (__) Mumps: (__) Rubella: (__) Varicella: (__) Pneumococcal: (__)

HepA: (__) Meningococcal: (__) HPV: (__)

_____ _____ _____
Signature of Medical Provider Print Name or Stamp Date

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE INSTRUCTIONS

This form *replaces a*ll forms dated before February 24, 2009. This District of Columbia Universal Health Certificate (DCUHC) will be used for entry into Child Care Facilities, Head Start and DC public, private and parochial schools.
Exception: It cannot be used to replace EPSDT forms or the Department of Health Oral Health Assessment Form. The DCUHC was developed by the DC Department of Health and follows the American Academy of Pediatrics (AAP) guidelines for child and adolescent preventive health care; from birth to 21 years of age. **This form is a confidential document,** consistent with the requirements of the *Health Insurance Portability and Accountability Act of 1996* (HIPAA) for health providers, and *the Family Educational Rights and Privacy Act of 1974* (FERPA) for educational institutions.

General Instructions: Please use a black ball point pen when completing this form.

Part 1: Child's Personal Information:
Parent or Guardian: Please complete all of your child's personal information including the child's last name, first and middle name, date of birth and gender. Also include your name, phone number, home address, the ward in which the address is located, and the name and phone number of an emergency contact in case you cannot be reached. Provide the name of the school or child care facility. Check the box that describes your child's type of health insurance coverage. If the child's type of insurance coverage is not listed, check "other" and write the type of coverage in the space provided. Write the name of your child's primary care provider (doctor). If your child does not have a primary care provider, write "none" in the space provided. **This form will not be complete without the parent or guardian's signature in Part 5.**

Part 2: Child's Health History, Examination & Recommendations: (To be completed by the health care provider). Please mark all relevant boxes.

- **Date of Health Exam**: All children must have a physical examination by a physician or certified nurse practitioner as per the AAP Guidelines. The date entered here must indicate the date of the examination.
- **WT:** Child's weight in either pounds (LBS) or kilograms (KG); **HT:** Child's height in either inches (IN) or centimeters (CM).
- **BP:** If a child is three years of age or older, write the blood pressure value in the box and check if normal or abnormal. If abnormal, provide an explanation and resolution in Part 2: Section A.
- **Body Mass Index (BMI):** If the child is 2 years of age or older, the BMI has to be calculated and recorded inclusive of percentile.
- **HGB/HCT:** Hemoglobin (HGB) or Hematocrit (HCT) is ***required* for Head Start children**. Also, anemia screening is recommended for menstruating adolescents based on AAP guidelines. Please record blood level and indicate which test was performed by circling HGB, HCT or both.
- **HEALTH CONCERNS:** The health care provider must perform the following health screens: asthma, seizure, diabetes, language, developmental/behavioral and other disorders that may require special health care needs." For any of the health screens where there are "HEALTH CONCERNS," the health care provider must check the box indicating that the proper referral has been made or the child is currently being treated (Rx) for the concern. IF there are NO/NONE "HEALTH CONCERNS", then check the **'NO" or None"** box in each health screening area.
- **SPECIAL NOTE:** "Annual Dentist Visit" – for children three years of age and older, the health care provider must indicate whether a dentist has screened or examined the child within the last 12 months. If "No", the child should be referred to a dentist.
- **A:** Please note any significant health history, conditions, communicable illness and restrictions that may affect the child's ability to perform in a school-related activity or program or mark "NONE".
- **B:** Please note any significant allergies that may require ***emergency medical care*** at a school-related activity or program or mark "NONE".
- **C:** Please note any long-term medications, over-the-counter drugs or special care requirements at a school-related activity or program or mark
- "NONE".
- **SPECIAL NOTE:** Please note any medications or treatments required at a school-related activity or program in Part 2: Section C and complete a Physician's Medication Authorization Order and attached it to the health certificate.

Part 3: Tuberculosis & Lead Exposure Risk Assessment & Testing:

• **TUBERCULOSIS (TB) RISK ASSESSMENT:** Perform risk assessment for TB as defined by the *AAP Tuberculin Skin Test Recommendations for Infants, Children and Adolescents in the 2006 AAP RED BOOK, 27th Ed., page 682.* Current DC regulations require one TST (Tuberculin Skin Test) for all children entering child care or school; whichever comes first. TST is also required for all children who are assessed as **HIGH RISK OF EXPOSURE.** Please note the test and mark the test outcome (negative or positive). **If the TST is positive,** then mark the chest X-Ray outcome (CXR) and whether the child was treated. **All positive TSTs must be reported to the DC T.B. Control Program on 202-698-4040.**
• **LEAD EXPOSURE RISKS:** DC law requires that all children are tested between 6 and 14 months of age and again between 22 and 26 months. DC law also requires that if a child is more than 26 months old and has not yet been tested for lead exposure, that child must be screened twice prior to age 6. Please document both the "Date" and "Result" of most recent lead test. Please indicate if "Pending." "Pending" results will be **valid for two months from date of testing** and will not exclude a child from school-related activity or program. **ALL lead tests must be reported electronically by labs to the DC Childhood Lead Poisoning Prevention Program. For detailed instructions, call 202-654-6036/6037. Providers may fax results to: 202-481-3770.**

Part 4: Required Provider (physician or nurse practitioner) Certification and Signature:
The provider will respond by marking "Yes" or "No" to the following statements:
The child was appropriately examined with a review of the health history;
The child is cleared for competitive sports (based on the assessment and consistent with the AAP Pre-participation Physical Evaluation 2nd Ed. (1997; and The child has received age-appropriate screenings (in accordance with AAP and EPSDT guidelines) within the current year. If "No" is marked, explain the reason in the space provided. All information will be kept confidential.

Part 5: Required Parent/Guardian Signatures. (Release of Health Information).
The parent or guardian must print their name; provide a signature and the date. By signing this section the parent or guardian gives permission to the health provider to share the health information on this form with the child's school, child care facility, camp or appropriate DC Government agency.

Forms are available online at **www.doh.dc.gov**

DISTRICT OF COLUMBIA UNIVERSAL HEALTH CERTIFICATE

Part 6: IMMUNIZATION INFORMATION

General Instructions: Please use black ball point pen when completing form

Child/Student Personal Information: Print clearly child/students last name, first name, and middle name/initial. Enter date of birth as mm/dd/yr. Indicate sex of child/student by checking female or male. Indicate name of school or child care facility child attends.

Section 1: Immunization Information – Enter clearly date (mm/dd/yy) vaccine(s) administered or attach equivalent copy with provider's signature and date. As required by D.C. Law 3-20, "Immunization of School Students Act of 1979" and DCMR Title 22, Chapter 1 (revised May 2, 2008), the following immunizations are required.

Instructions: Find the age of the child/student in the column labeled "Child's Current Age". Read across the row for each required vaccine. The number in the box is the number of doses required for that vaccine based on the CURRENT age or grade level of the child. The age range in the column does not mean that the child has until the highest age in that range to meet compliance. Any child whose age falls within that range must have received the required number of doses based on his/her CURRENT age in order to be in compliance.

Vaccine types and dosage numbers required for children enrolled in Child Care Programs[1, 2]

Child's Current Age	DTaP/DTP/DT	Polio	Hib[7]	MMR[8]	Varicella[9] (Chickenpox)	Hepatitis B[10]	Hepatitis A[11]	Pneumococcal Conjugate[12]	Meningococcal	Human Papillomavirus (HPV)
Less than 2 months	0	0	0	0	0	1	0	0	0	0
2 – 3 months	1	1	1	0	0	1	0	1	0	0
4 – 5 months	2	2	2	0	0	2	0	2	0	0
6 – 11 months	3	3	2 / 3	0	0	3	0	3	0	0
12 – 14 months	3	3	3 / 4	1	1	3	1	4	0	0
15 – 23 months	4	3	3 / 4	1	1	3	1	4	0	0
24 – 47 months	4	3	3 / 4	1	1	3	2	4	0	0
48 – 59 months	5[3]	4[6]	3 / 4	2	2	3	2	4	0	0

Vaccine types and dosage numbers required for children enrolled in Public, Charter, Parochial and Private Schools[1, 2]

Grade Level		DTaP/DTP/DT/ Td/Tdap	Polio[6]	Hib	MMR[8]	Varicella[9] (Chickenpox)	Hepatitis B[10]	Hepatitis A[11]	Pneumococcal Conjugate	Meningococcal[13]	Human Papillomavirus[14] (HPV)
Grade	(Ungraded)										
Grades K – 5	(5 – 10 yrs)	5[3, 4]	4	0	2	2	3	2	0	0	0
Grades 6 - 12	(11 – 18+ yrs)	6[4, 5]	4	0	2	2	3	2	0	1	3

[1]Spacing: Doses must be appropriately spaced and given at appropriate age. Vaccine doses administered up to 4 days before minimum interval or age are counted as valid. Exception: Two live virus vaccines that are not administered on same day, must be separated by a minimum of 28 days.

[2]Exemptions: Medical exemptions from immunizations may be granted for valid reasons with proper documentation from health care provider (Section 2). Blood titers may be obtained in lieu of immunizations (Section 3). A copy of the lab report must be submitted to school/child care facility. Documentation for religious exemptions must be submitted by parent/guardian to the school/child care facility.

[3]DTP/DTaP: Five (5) doses of DTP/DTaP are required at 4 years of age for school entry unless 4th dose was given on or after the 4th birthday. Interval between dose 4 and dose 5 of DTP/DTaP must be 6 months.

[4]Td/Tdap: Three (3) doses of Td required if primary series started after 7th birthday. If ≥11 years old, one of three doses must be tetanus, diphtheria, and pertussis (Tdap) vaccine dose. Tdap booster required five years after last dose of tetanus, diphtheria-containing vaccine. Td booster required every 10 years.

[5]Tdap: Student must meet the minimum prior requirement for the 4th or 5th doses of DTP/DTaP vaccine and have one (1) dose of Tdap.

[6]Polio: Four doses are required at age 4 for school entry, unless the third dose of an all-IPV or all-OPV schedule is given on or after the 4th birthday, in which only 3 doses are needed. However, if the sequential or mixed IPV/OPV schedule was used, four doses are required to complete the primary series. Polio is not routinely given for students ≥ 18 years of age.

[7]HIB: The number of primary doses is determined by vaccine product and age the series begins. The last dose of Hib must be administered on or after 12 months of age, however, if only one (1) dose is given, it must be administered on or after 15 months of age. The vaccine is not required for students 5 years of age and older.

[8]MMR: Second dose required at 4 years of age. First dose must be given on or after the first birthday. Second dose may be given one month after the first dose. MMR and Varicella must be given on the same day or separated by 28 days.

[9]Varicella: Second dose required at 4 years of age. First dose must be given on or after the first birthday. If first dose given between 12 months and 12 years of age, second dose is given 3 months after first dose; if first dose is given at ≥ 13 years, 2nd dose may be given one month after first dose. The Varicella vaccine is not required for a student who has a history of chickenpox verified by a primary care provider and includes the month and year of disease.

[10]Hepatitis B: If monovalent hepatitis B vaccine is given in conjunction with a combination vaccine, i.e. DTaP-IPV-Hepatitis B, four doses of hepatitis B is acceptable; however, dose 3 or 4 must be given at age 24 weeks or later and at least 8 weeks after the previous dose. If monovalent hepatitis B vaccine is administered, dose 3 must be given at least 16 weeks after dose one and at least 8 weeks after dose 2. For students 11-15 years old, a clearly documented 2-dose adult hepatitis B vaccine (Recombivax) is acceptable.

[11]Hepatitis A: Required for students born on or after January 1, 2005.

[12]Pneumococcal: The number of pneumococcal doses required depends on the student's current age and the age when the first dose was administered. Administer 1 dose to healthy children aged 24 through 59 months who are not completely vaccinated for their age. The vaccine is not required for students 5 years of age and older.

[13]Meningococcal: Required at age 11 years of age and older.

[14]HPV: Required for students entering the sixth grade for the first time. Information concerning human papillomavirus (HPV) and the HPV vaccine must be provided to parent/guardian or student. A parent/guardian may sign a form approved by the Department of Health to "Opt-Out".

Section 2: Medical Exemption – Complete this section if there exist a medical contraindication which prevents the child from receiving one or more immunizations in a timely manner consistent with D.C. Law 3-20 & ACIP recommendations. Check all contraindicated vaccines and provide a reason for contraindication. If the medical exemption is permanent, check appropriate space. If medical exemption is temporary, check the appropriate space and enter the date it expires. Medical provider must sign, print name or stamp and date this section.

Section 3: Alternative Proof of Immunity – Complete this section if blood titers are used to show proof of immunity. Check vaccine(s) which blood titer were obtained. Attach a copy of the titer results. Medical provider must sign, print name or stamp and date this section.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

District of Columbia Immunization Requirements--School Year 2011 – 2012

All students attending school in the District of Columbia must present proof of immunizations by the first day of school. The specific immunization and dosage depends on the child's age and how long ago they were vaccinated. Please use the list below for guidance and check with your child's school nurse or health care provider for additional information.

Requirements for a Child 2 Years or Older Entering Preschool or Head Start

Dosage	Name of Immunization
4	Diphtheria/Tetanus/Pertussis (DTaP)
3	Polio
1	Varicella (chickenpox) – if no history of disease. The disease history MUST be verified by a health care provider and documentation MUST include the month and year of disease.
1	Measles, Mumps & Rubella (MMR)
3	Hepatitis B
2	Hepatitis A
3 or 4	Hib (Haemophilus Influenza Type B) The number of doses is determined by brand used.
4	PCV (Pneumococcal)

Requirements for a Child 4 Years or Older Entering Pre-Kindergarten

Dosage	Name of Immunization
5	Diphtheria/Tetanus/Pertussis (DTaP)
4	Polio
2	Varicella (chickenpox) – if no history of disease. The disease history MUST be verified by a health care provider and documentation MUST include the month and year of disease
2	Measles, Mumps & Rubella (MMR)
3	Hepatitis B
2	Hepatitis A
3 or 4	Hib (Haemophilus Influenza Type B) The dose is determined by the brand used.
4	PCV (Pneumococcal)

Requirements for a Child 5-10 Years Old Entering Kindergarten thru 5th Grade

Dosage	Name of Immunization
5	Diphtheria/Tetanus/Pertussis (DTaP)
4	Polio
2	Varicella (chickenpox) – if no history of disease. The disease history MUST be verified by a health care provider and documentation MUST include the month and year of disease
2	Measles, Mumps & Rubella (MMR)
3	Hepatitis B
2	Hepatitis A (if born on or after 01/01/05)

Requirements for a Child 11 Years and Older Entering 6th through 12th Grade

Dosage	Name of Immunization
5	Diphtheria/Tetanus/Pertussis (DTaP)
1	Tdap (if 5 years since last dose of DTP/DTaP/Td)
4	Polio
2	Varicella (chickenpox) – if no history of disease. The disease history MUST be verified by a health care provider and documentation MUST include the month and year of disease
2	Measles, Mumps & Rubella (MMR)
3	Hepatitis B
1	Meningococcal
3	Human Papillomavirus Vaccine (HPV) – Female students entering 6th, 7th, and 8th grades only. Parents may sign a vaccine refusal certificate, included in this packet.

CONFIDENTIAL FORM- SIDE ONE

Please review instructions on side two

District of Columbia Oral Health (Dental Provider) Assessment Form

Part 1. Child's Personal Information

Child's Last Name	*Child's First & Middle Name*	*Date of Birth*	*Gender:* ☐ *M* ☐ *F*	*School or Child Care facility:*

Parent/Guardian Name	*Telephone1:* ☐ *Home* ☐ *Cell* ☐ *Work*	*Home Address:*	*Ward*

Emergency Contact:	*Telephone2:* ☐ *Home* ☐ *Cell* ☐ *Work*	*City/State (if other than D.C.)*	*Zip code:*

Race/Ethnicity: ☐ *White Non Hispanic* ☐ *Black Non Hispanic* ☐ *Hispanic* ☐ *Asian or Pacific Islander* ☐ *Other*_____

Primary Care Provider (Medical):	*Dentist/Dental Provider:*	☐ *Medicaid* ☐ *Private Insurance* ☐ *None* ☐ *Other*_____

Part 2. Child's Clinical Examination (to be completed by the Dental Provider)

Date of Exam _____

(Please use key to document all findings on line next to each tooth)

Tooth #	Tooth #	Tooth #	Tooth #
1 _____	17 _____	A _____	K _____
2 _____	18 _____	B _____	L _____
3 _____	19 _____	C _____	M _____
4 _____	20 _____	D _____	N _____
5 _____	21 _____	E _____	O _____
6 _____	22 _____	F _____	P _____
7 _____	23 _____	G _____	Q _____
8 _____	24 _____	H _____	R _____
9 _____	25 _____	I _____	S _____
10 _____	26 _____	J _____	T _____
11 _____	27 _____		
12 _____	28 _____		
13 _____	29 _____		
14 _____	30 _____		
15 _____	31 _____		
16 _____	32 _____		

Key (Check Appropriate)

S - Sealants

X - Missing teeth

● Restoration

|| Non-restorable/ Extraction

1D-One surface decay

UE- Unerupted Tooth

2D-Two surface decay

3D-Three surface decay

4D-More than three surface decay

Part 3. Clinical Findings and Recommendations (Please indicate in Finding column)

	Findings	Comments
1. Gingival Inflammation	**Y N**	
2. Plaque and/or Calculus	**Y N**	
3. Abnormal Gingival Attachments	**Y N**	
4. Malocclusion	**Y N**	
5. Other (e.g. cleft lip/palate)		
Preventive services completed ☐ Yes ☐ No		

Part 4. Final Evaluation/Required Dental Provider Signatures

This child has been appropriately examined. **Treatment** ☐ is complete. ☐ is incomplete. Referred to _____

DDS/DMD Signature	*Print Name*	*Date*

Address

Phone	Fax

Part 5. Required Parent/Guardian Signatures

Parent or Guardian Release of Health Information.

I give permission to the signing health examiner or facility to share the health information on this form with my child's school, childcare, camp, or Department of Health

PRINT NAME of parent or guardian

SIGNATURE of parent or guardian	*Date*

Instructions For Completion of Oral Health Assessment Form: District of Columbia Child Health Certificate

This Form replaces the Dental Appraisal Form used for entry into DC Schools, all Head Start programs, Childcare providers, camps, after school programs, sports or athletic participation, or any other District of Columbia activity requiring a physical examination. The form was developed by the DC Department of Health and follows the American Academy of Pediatric Dentistry (AAPD) Guidelines on Mandatory School-Entrance Oral Health Examinations. AAPD recommends that a child be given an oral health exam within 6 months of eruption of the child's first tooth and no later than his or her first birthday. The DC Department of Health recommends that all children 3 years of age and older have an oral health examination performed by a licensed dentist and have the DC Oral Health Assessment Form completed. This form is a confidential document. Confidentiality is adherent to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) for the health providers, and the Family Education Rights and Privacy Act (FERPA) for the DC schools and other providers.

General Instructions: Please use black ball point pen when completing this form.

Part 1: Child's Personal Information
Please complete all sections including child's race or ethnicity. Please indicate the ward of your home address. List primary care provider, dental provider, and type of dental insurance coverage. If child has no dental provider and is uninsured, then please write **"None"** in each box. This form will not be complete without **Parent or Guardian** signature in Part 5.

Part 2: Child's Clinical Examination: Dental Provider: Form must be fully completed. The Universal Tooth Numbering System is used.
Please use key to document all findings for each tooth. An '**X**' signifies a missing tooth (teeth) with no replacement; | | non-restorable/extraction; **UE:** unerupted tooth; **S:** Sealants; ● Restoration; **1D:** one surface decay; **2D:** two surface decay; **3D:** three surface decay; **4D:** more then three surface decay

- The Key should be used to designate status for each tooth at time of examination on the Oral Health Assessment Form.
- If a portion of an existing restoration is defective or has recurrent decay, but part of the restoration is intact, the tooth should be classified as a decayed tooth. If one surface has decay, then mark as **1D;** if two surface has decay then mark as **2D**.
- Key **UE:** unerupted, does not apply to a missing primary tooth when a permanent tooth is in a normal eruption pattern.

Part 3: Clinical Findings and Recommendations

- Circle **Yes** or **No** in Findings Column
- For **Yes**, please explain in the Comments Section.

1- Advance periodontal conditions (pockets etc., will be noted under gingival inflammation).
1- Gingival inflammation adjacent to an erupting tooth is **NOT** noted.
1- Inflammation adjacent to orthodontically banded teeth or a dental appliance – whether fixed or removable is noted.
2- Indicate if there is sub and/or supra gingival plaque and or calculus and areas where present.
3- All gingival tissues must be free of inflammation e.g. gingiva is pale pink in color and firm in texture for a finding of 'NO' to be recorded.
3- Frenum attachments labial, sublingual, etc., will be noted under the Abnormal Gingival Attachment Indicator Code if they are the cause of a specific problem- e.g., spacing of central incisors, speech impediment, etc.
4- Status of orthodontic condition should be noted under Malocclusion. Classification of occlusion is: Class I, Class II, Class III, an overbite, over jet, cross-bite or end to end.
5- Other is to be used, together with comments, for conditions such as cleft lip/palate.

- Indicate whether oral health preventive services such as prophylaxis, sealant and or fluoride treatment have been administered.

Part 4. Final Evaluation/Required Dental Provider Signature; Indicate whether the child has been appropriately examined and if treatment is complete. If treatment is incomplete refer patient for follow up care. Dentist must **sign, date, and provide required information.**

Part 5 Required Signatures. This Form Will Not Be Complete Without Parent or Guardian Signature & Date
The parent or guardian must print, sign, and date this part. By signing this section the parent or guardian gives permission to the dentist or facility to share the oral health information on this form with the child's school, childcare, camp, Department of Health, or the entity requesting this document. All information will be kept confidential.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

Human Papillomavirus (HPV) Vaccination Opt-out Certificate

INSTRUCTIONS FOR COMPLETING THIS FORM
Section 1: Enter student information.
Section 2: Have parent/guardian or student (if 18 years of age or older) sign and date after reading the HPV Information Statement.

Section 1: Student Information			
Name of School:			
Student Name:		Date of Birth:	Grade:
Street Address:	City/State:	Zip Code:	Phone:
Name and Address of Healthcare Provider:	City/State:	Zip Code:	Phone:

Beginning in 2009 and in accordance with D.C.Law17-10 (Human Papillomavirus Vaccination and Reporting Act of 2007), the parent or legal guardian of a female student enrolling in 6th, 7th, and 8th grade for the first time at a school in the District of Columbia is required to submit certification that the student has:

1. Received the Human Papillomavirus (HPV) vaccine; or
2. Not received the HPV vaccine because:
    a. The parent or guardian has objected in good faith and in writing to the chief official of the school that the vaccination would violate his or her religious beliefs;
    b. The student's physician, his or her representative or the public health authorities has provided the school written certification that the vaccination is medically inadvisable; or
    c. The parent or legal guardian, in his or her discretion, has elected to opt out of the HPV vaccination program by signing a declaration that the parent or legal guardian has been informed of the HPV vaccination requirement and has elected not to participate.

Section 2: Student Information

Opt-Out for Human Papillomavirus (HPV) Vaccine

I have received and reviewed the information provided on HPV and the benefits of the HPV vaccine in preventing cervical cancer and genital warts if it is given to preteen girls. After being informed of the risk of contracting HPV and the link between HPV and cervical cancer, I have decided to opt-out of the HPV requirement for the above named student. I know that I may re-address this issue at any time and complete the required vaccinations.

_____ _____
Signature of Parent/Guardian or Student (if 18 years or older) Date

_____
Print Name of Parent/Guardian or Student (if 18 years or older)

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

HUMAN PAPILLOMAVIRUS (HPV) INFORMATION STATEMENT

Genital human papillomavirus (HPV) is the most common sexually transmitted virus in the United States. There are about 100 types of HPV. Most infections don't cause any symptoms and go away on their own. HPV is important mainly because it can cause cervical cancer in women and several less common types of cancer in both men and women. It can also cause genital warts and warts of the upper respiratory tract. There is no treatment for HPV, but the conditions it causes can be treated.

About 20 million people in the U.S. are infected, and about 6.2 million more get infected each year. HPV is spread through sexual contact. More than 50% of sexually active men and women are infected with HPV at some time in their lives. Every year in the U.S., about 10,000 women get cervical cancer and 3,700 die from it with rates of cervical cancer in DC being higher than national averages.

HPV vaccine is an inactivated vaccine (not live) which protects against 4 major types of HPV. These include 2 types that cause about 70% of cervical cancer and 2 types that cause about 90% of genital warts. HPV vaccine can prevent most genital warts and most cases of cervical cancer.

Protection is expected to be long-lasting, but vaccinated women still need cervical cancer screening because the vaccine does not protect against all HPV types that cause cervical cancer.

HPV vaccine is routinely recommended for girls 11-12 years. Doctors may give it to girls as young as 9 years. It is important for girls to get HPV vaccine before their first sexual contact because they have not been exposed to HPV. For these girls, the vaccine can prevent almost 100% of disease caused by the 4 types of HPV targeted by the vaccine. However, if a girl or woman is already infected with a type of HPV, the vaccine will not prevent disease from that type. It is still recommended that girls or women with HPV get vaccinated.

The vaccine is also recommended for girls and women 13-26 years of age who did not receive it when they were younger. It may be given with any other vaccines needed.

HPV vaccine is given as a 3-dose series:

- **1st Dose: Now**
- **2nd Dose: 2 months after Dose 1**
- **3rd Dose: 6 months after Dose 1**

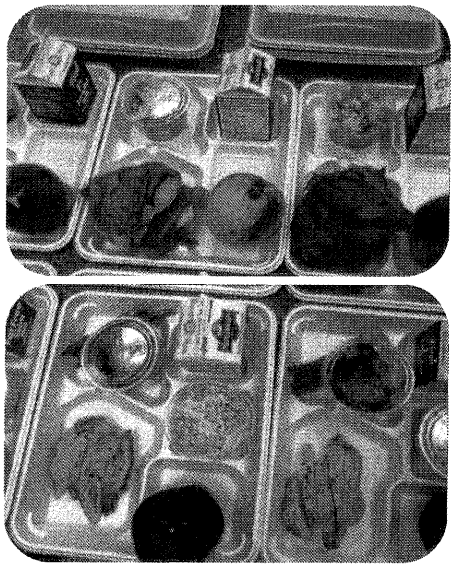
People who have had a life-threatening allergic reaction to yeast, are pregnant, and/or have a moderate to severe illness should not receive the vaccine. Side effects are mostly mild, including itching, pain, redness at the injection site and a mild to moderate fever.

If you need additional information, please contact your healthcare provider. You can also contact the D.C. Department of Health Immunization Program at (202) 576-9342 or the Centers for Disease Control and Prevention (CDC) at 1-800-CDC-INFO (1-800-232-4636).

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

DCPS Food Service, 2011-12

www.dcps.dc.gov/DCPS/foodservices



In the 2011-2012 school year, the DCPS Office of Food and Nutrition Services will continue to make healthy, appetizing breakfast, lunch and supper meals available to DCPS students. These meals will meet or exceed the nutritional requirements of the DC Healthy Schools Act. Twenty percent of all produce served will come from the Mid-Atlantic region and only skim and 1 percent white milk will be available to students.

Menus with information on nutrition and fruit and vegetable origins will be posted by school on the DCPS Food Services website, in school cafeterias and in main offices.

Many elementary schools will serve breakfast in the classroom, with most middle and high schools offering breakfast from a convenient "grab and go" kiosk. Lunch will feature new seasonal specialties as well as signature items from last school year. DCPS' after school programs will continue to serve students a light supper at the end of their day.

How to Register for School Meals

(The FARM Application will not be available until Summer 2011)

This year, students at 90 DC public schools will eat all meals for free and not be required to submit free and reduced meal applications, because these schools have been certified by the USDA as Provision 2. Students attending non-Provision 2 schools must submit the *Family Application for School Lunch and Breakfast* (FARM) to their school liaison to determine if they qualify for free or paid lunches. The FARM application will be available the summer of 2011 and is NOT included in the enrollment packet. All students classified as "reduced" by the USDA will not pay for school lunches.

How to Pay for School Meals

Paying for school meals is easier than ever. This year, students and parents can prepay for meals using a valid credit or debit card through MyLunchMoney.com, a secure online payment system for school meals. As in prior school years, all schools accept prepayments made by bringing cash or check to the school cafeteria, made payable to the DC Treasury. Specific schools also have cashless kiosks available in the cafeteria for students to deposit cash directly into their account.

Allergies and Accommodations

Students with special dietary needs, including food intolerances and allergies, should submit to their school nurse a Student's with Special Dietary Needs Form, available on the Food Services webpage, to request a food accommodation. This form must be completed and signed by a licensed medical provider.

Students who require dietary accommodations for religious or philosophical reasons should fill out the Religious/Philosophical Dietary Accommodations Form, also available on the Food Services webpage. This form requires the signature of a parent or guardian.

Food Feedback

DCPS Food Services is looking for your feedback! If you have questions, comments, or concerns about school meals, you can submit them through the online feedback form available on the Food Services webpage or by emailing food.dcps@dc.gov or calling 202-442-5122. Any inquiries received will be responded to by the next business day.